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ABSTRACT

The 1908 publication of "A Mind That Found Itself" by Clifford Beers initiated the mental hygiene movement and a concern for the prevention of mental disorders. Primary prevention movements of the early 1900's recognized the need to deinstitutionalize mental health by bringing services and intervention to the community, recognized the influences of environmental and societal factors, and focused on the young as targets for intervention. The Child Guidance Movement grew and child guidance clinics proliferated. The eugenics movement advocated the prohibition of marriages between the handicapped, the feeble-minded, and between cousins in efforts to prevent insanity, and twentieth century writers have suggested combining eugenics with mental hygiene principles. The federal government became officially involved in prevention in 1930, and the National Mental Health Act was passed in 1946. Studies in the 1950's explored the relationship of environmental factors to mental disorders; the literature on primary prevention expanded in the 1960's and 1970's. A critical sense emerged and standards began to be questioned. A cyclical interest in prevention has occurred throughout the century and progress has been hindered by several recurrent and interacting factors. Contemporary researchers need to establish and follow consistent evaluation strategies. (NRB)

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A Brief History of Primary Prevention in the Twentieth Century

1908 to 1979

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A Brief History of

Primary Prevention in the Twentieth Century: 1908 to 1979

Primary prevention of mental disorders appeared to be a popular and fashionable concept in the 1970's. There was, however, often an implicit assumption in the literature that primary prevention was also a concept of the seventies. It is the purpose of this paper, in part, to dispel that notion. The idea has been around for more than this century, despite its curious periodic rediscovery. This paper critically explores the recurrence of primary prevention thought and practice in the twentieth century through an historical perspective.

From a definitional standpoint, various notions of prevention and its differing levels have been available for some time, both from a physical and public health perspective (Leavell and Clark, 1958; Commission on Chronic Illness, 1952) as well as from the perspective of mental health (Bloom, 1968). Prevention has been identified at the primary, secondary and tertiary levels. Primary prevention aims to reduce the incidence (i.e. the number of new cases occurring in a population in a specified time period) of a disorder using such strategies as the population-wide approach, milestone approach, or the targeting of groups considered to be at high risk (Bloom, 1977). Secondary and tertiary prevention, on the other hand, involve efforts to reduce the prevalence (i.e., the number of existing cases in a population in a specified time period) of a disorder. Secondary prevention efforts are primarily devoted to early identification and treatment of a disorder, while tertiary efforts have been characterized as rehabilitative in nature.

Primary prevention in the twentieth century focuses not only on prevention of "badness" as has been the focus of other movements (e.g. religious and socialist) but also expands the foci of primary prevention to include the fostering of positive development and optimal health. Kessler and Albee (1977), for example, in reviewing the literature of primary prevention conclude that practically every effort aimed at improved child rearing, increasing effective communication, building inner control and self esteem, reducing stress and pollution, and the like- in short everything aimed at improving the human condition, at making life more fulfilling and meaningful- may be considered part of primary prevention of mental or emotional disturbance (p. 351).

In a similar view, Ansbacher (1977) has suggested positive mental health as a worthwhile objective of primary prevention efforts, with positive mental health defined as an orientation or striving on the socially useful side of life, a sense of ultimate usefulness to humanity rather than existing norms (p. 6).

As Caplan (1969) has pointed out, prevention efforts per se did not begin in mid-twentieth century. As early as 1880 a reform group existed called the National Association for the Protection of the Insane and the Prevention of Insanity. Even before that time prevention was a common concern among mid-nineteenth century superintendents of asylums. They felt that certain populations were at high risk and that preventive efforts were best directed at delimiting these populations. Such groups included the children of the insane, isolated persons, dark-haired persons, and the idle rich. At special risk, however, were young children. Since children were to be the special targets of preventive efforts again in the 1920's and 1930's during the child guidance movement and again during the 1960's and 1970's, it is interesting to note that the rationale in the later

movements had much in common with the earlier one. In Caplan's words:

. . . Superintendents [in mid-nineteenth century] felt that the largest and most critical group at risk was that of young children, whose impressionable brains were being molded for the first time by their upbringing and education.

. . . Practitioners held that healthy mental development in children depended on maintaining a balance between influences that cultivated the intellectual and moral character and those that acted on physical medium of the brain (pp. 14-15).

The Mental Hygiene Movement (1908-1960)²

Any survey or history of the concept of primary prevention in the twentieth century must begin with Clifford Beers and his book, A Mind That Found Itself, published in 1908. Beers' book initiated the mental hygiene movement, which concerned itself not only with the reform of conditions for the mentally ill but also with the prevention of mental disorders.³ Caplan (1969) provides a succinct summary of the mental hygiene movement which, she says, marked a turning point in psychiatric history "when community forces made a concerted attack on institutional stultification and mismanagement, and when psychiatry began to move out of asylums into schools, into child guidance and out-patient clinics, and into the army in an attempt to eradicate insanity in the general population" (p. 179).

In May 1908 the first mental hygiene society was established in Connecticut, and in 1909 the National Committee for Mental Hygiene was established (Reisman, 1976). Among the objectives of the Connecticut Society were the following statements about prevention: "The chief purpose of this Society shall be to work for conservation of mental health: to prevent nervous and mental defects: . . . to secure and disseminate reliable

information on these subjects. . ." (Winslow, 1934, p. 304).

In speaking of the history of the movement Winslow states that at their early meeting in 1908 the Connecticut group . . .

extended their vision both in space and time. They visualized, not a single patient, but a whole community: and they considered each member of that community as an individual whose mental and emotional status was determined by definite causative factors and whose compelling need was for prevention rather than cure . . . (1934, pp. 304-305).

In 1917 the journal Mental Hygiene began publication, with the movement gaining an international following in the twenties and thirties. Preventive efforts increasingly focused on the early developmental years as the primary target area, and in 1922 the National Committee for Mental Hygiene began waging a campaign for the creation of children's clinics as part of a response to the current child welfare movement (Rossi, 1962). Child Guidance Clinic Movement (1920-1955)

As a specific manifestation of the focus on the developmental years, the U. S. Children's Bureau in the early 1920's began investigating ". . . ways of meeting the needs of parents in coping with behavior problems [in preschool-age children]" through the work of Dr. Douglas Thom. In 1946 this effort was considered as the earliest, organized effort ". . . to study the methods by which society and community could undertake a preventive mental health program for the [preschool] child" (National Neuropsychiatric Institute Act, Hearings . . . on S. 1160, 76th Cong., 2nd sess., 1946, p. 95).

The rationale seemed to be a version of the bent-twist theory that adult pathology could be prevented by an attack on childhood problem behaviors; and this led to the child guidance movement as a "favorite son" of the mental hygiene movement. Child guidance clinics proliferated during these years, seemingly evolving from William Healy's Psychopathic Institute for

children established in 1909 in Chicago. Concerned with research into etiology as well as diagnosis and treatment, his clinic was one of the first to use an interdisciplinary team approach (Rossi, 1962).

Dr. Thom (who preferred the name "habit clinics" to "child guidance clinics") had published a manual of the organization and practice of his original "habit clinics" in Boston as early as 1923. His clinics consisted of a team of psychiatrist, psychologist, and social worker assigned to each case, and the preventive intent of the work can be gleaned from the statement of purpose:

It is the purpose of such an approach to understand and eventually to straighten out asocial and undesirable tendencies before they become a fixed part of the child's personality make-up. If this is done many children will approach adolescent and adult life unhampered by the crippling influences of their early training and unhappy experiences. There is reason to believe that a relationship exists between the emotional instabilities and conduct disorders of early life and the problems of delinquency and neurotic disturbances later on (Thom, 1939, p. 5).

By 1932 there were 674 child guidance clinics in 34 states, with more than 500 created between 1922 and 1932 (Beers, 1934, Appendix II). (However, by 1946, there were reportedly only 260 child guidance clinics [Rennie, 1947]).

In addition to guidance clinics as insurance against adult pathology, other kinds of clinics, including mobile units to serve rural areas, were developed as well. Hendrick Lindt speaks of these in Twentieth Century Mental Hygiene: New Directions in Mental Health:

The Commonwealth Fund, with the National Committee for Mental Hygiene, established [in the 1920's] as demonstration centers a network of child guidance clinics throughout the country. Their purpose was to educate the community in regard to emotional problems of children and their treatment . . .

Another significant development was the appearance of rural Mental Hygiene traveling clinics organized in the local State Hospital. . . . who visited rural centers at stated intervals and worked closely with schools, courts, social agencies, and churches. These clinics reached the height of their development during the 1930's, but because of the limits imposed upon treatment by lack of time, were usually largely diagnostic in character (1950, pp. 80-81).

Although prevention has had a long history, it has not been without detractors. Even at this early date there were criticisms leveled at preventive ideas, charging that no proof existed that given measures were in fact preventive. One rejoinder, by an English psychologist speaking in 1922, implied that proof would come once preventive efforts were begun (i.e., that the population of mental hospitals would then decrease) (Craig, 1923).

By 1950 the high aims of the child guidance movement could be seen as significantly modified. Although the goals had been those of primary prevention, in actual practice the clinics were engaged in secondary and tertiary prevention. That the emphasis had shifted is obvious from Lindt's 1950 statements that:

. . . Early clinics set as their goals the prevention of juvenile

delinquency and of mental illness. Present day standards are more modest . . . 'out-patient psychiatric help' is shown not to be an insurance against future ill health but an aid to currently better functioning (p. 93).

The mental hygiene movement also made attempts to study larger environmental and social forces as preventive measures. In January 1930 the first International Mental Hygiene Congress was held in Washington, D. C. Among the topics addressed were "Organization of community facilities for prevention, care, and treatment," "Parent and teacher training," and "Marital relationships" (First International Mental Hygiene Congress, 1930). In a statement of its accomplishments to 1934, the National Committee for Mental Hygiene included such "successes" as having promoted the modification of environmental conditions conducive to mental disorder and of having explored the relationship of mental defects to social problems.

Other statements of the time also demonstrated a contemporary assumption that environmental conditions could be attacked as a preventive maneuver and as an aid in fostering good mental hygiene. As early as 1918 the New York State Hospital Commission recommended that extreme poverty be eliminated as a preventive measure (Notes and Comments, 1918). And in 1919 the United States Public Health Service published a list of nine items which characterized their plans for prevention in the mental hygiene area and which would be carried out "as rapidly as funds become available." The list included "investigating mental status in relation to certain constitutional diseases and drug addiction"; "cooperation

with the industrial hygiene unit of the United States Public Health Service in the studies and investigations of the mental status of workmen as related to output, fitness for the job, protection from health and injury hazards, and permanence of employment"; "cooperation with the child hygiene unit of the service in the study and investigation of insanity in children and of the personality of the potentially insane"; and "cooperation with the Division of Venereal Diseases in studies and investigations of the mental status of prostitutes and of the relation of venereal diseases to mental disorders" (Mental Hygiene, 1919, p. 270).

Concurrently, education of the public was deemed as highly regarded as child guidance. Such public education took the form of "promotion of mental health." By 1934 the National Committee for Mental Hygiene had developed mental hygiene instruction for parents and teachers, for example, and had promoted the inclusion of "mental hygiene" courses at many educational levels (National Committee for Mental Hygiene, 1934). By 1950 other "promotional" activities advocated by hygienists included sex education classes, human relations classes, establishment of nursery schools, "mother's classes" for pregnant women, well baby classes, and "marriage clinics" (Thompson, 1950).

The Eugenics Movement (1860-1955)

Although never as widespread or popular as the mental hygiene movement, the eugenics movement, which began in the last half of the nineteenth century, approached the issue of prevention of pathology with a solution that began prior to conception. Many early conceptualizers of primary prevention (e.g., Ray, 1864) emphasized eugenics in their formu-

lations, particularly in response to the waves of immigrants pouring into the United States in the period after the Civil War. But they were also influenced by the rise of such concepts as Social Darwinism and hereditary insanity. Eugenics seemed to many to be not only possible but necessary. The prohibition of marriages between the handicapped, the feeble-minded, and between cousins was widely advocated in efforts to prevent insanity (see Caplan, 1969). However, as a preventive tool eugenics continued to be advocated well into the twentieth century.

Several twentieth-century writers suggested combining eugenics with fashionable mental hygiene principles for even greater preventive efforts. The following two examples are representative. In 1921 H. M. Pollock wrote of a three-point preventive approach: 1. decreasing environmental stresses and increasing natural resistance; 2. checking the procreation of defective stock; and 3. increasing the procreation of normal stock. Bemoaning the fact that sterilization procedures lacked public support, Pollock advocated the prohibition of marriage of "persons with marked intellectual or temperamental abnormalities" (p. 811). Additionally he supported public access to genealogical records in the belief that "few normal persons would be rash enough knowingly to join fortunes with a neuropathic or degenerate family stock. . . . Eugenic bureaus, by collecting data concerning family histories and by emphasizing the importance of family stock, would naturally promote good marriages among persons of good stock. . . ." (pp. 811-812). A. Ruggles in 1934 maintained that proper breeding could be accomplished through education in the principles of eugenics.

Education must begin in earliest youth, and the parent, the doctor, the clergyman, and the lawyer must actively take part in such an educational program, stressing the value of breeding our human stock up and not down; of breeding neurotic stock, not with other neurotic stock, with that which is biologically and psychologically more stable. (pp. 88-89).

By 1939 there were 29 states having laws providing for the sterilization of the "biologically unfit," with over 33,000 involuntary sterilizations having been performed in state institutions under these laws (Ruch, 1944). By 1953 Gurenberg felt called upon to state that there simply was not sufficient evidence to establish sterilization as a preventive measure for mental disease.⁵ Lemkau in 1955 devoted a section of his book, Mental Hygiene in Public Health, to eugenics and urged that public health officers have knowledge of eugenics because they may have "direct responsibility in deciding conditions under which sterilization may be carried out" (p. 150). Twenty-two years later Kessler and Albee recognized that eugenics still had the potential to be used in primary prevention: "In the extreme, primary preventive efforts might be expected to lead eventually to such practices as social control of child bearing, with licenses issued only to persons genetically sound; prenatal tests which could result in therapeutic abortions, and sperm and ova banks" (1977, p. 364).

Federal Involvement (1930's & 1940's)

Although the Children's Bureau and the United States Public Health Service were both somewhat involved in encouraging preventive efforts during the twenties, the role of the federal government in prevention

officially began in 1930 when the Narcotics Division of the Treasury Department changed its name to the Division of Mental Hygiene in recognition of rehabilitation of addicts through a "mental health approach." This same act also authorized "such studies and investigations, as may be necessary, . . . of the causes, prevalence, and means of prevention and treatment of mental and nervous diseases." Furthermore, the surgeon general was required to report to the Secretary of the Treasury each year the results of these such studies and investigations (46 Stat., p. 587, Ch. 488, 1930).

The surgeon general at that time spoke openly in favor of preventive efforts. In addressing the Maryland Hygiene Society in 1930, he supported research and preventive efforts: "A broad program of mental hygiene should consider where and under what conditions mental disease occurs and aid in developing appropriate means for early recognition and treatment of mentally ill persons. . . . It should also contemplate investigations and studies with respect to the underlying reasons or causes of mental ill health and interpret and diffuse such knowledge to the public and medical profession" (Cumming, 1930, p. 729). Five years later, in a speech before the American Public Health Association, the assistant surgeon general spoke on "the place of mental hygiene in a federal health program." He characterized three groups of mental disorders which could be affected by preventive efforts, and he made a point to emphasize the environmental variables involved, such as nutrition and industrial hazards.

. . . Those mental disorders involving exogenous poisons and infections are mass phenomena of disease demanding mass control

and the application of prevention measures embracing those broad public health policies of which mental hygiene is but a part. Reference may be made, also, to such situations as those involving alcohol, drugs, industrial hazards, venereal diseases, infections involving the central nervous system primarily, nutritional situations, child and maternal welfare, and other adult problems, all carrying with them a mental health factor that must be met eventually through the regularly constituted health agency amplified in its organization and outlook to meet these special health factors (Treadway, 1936, pp. 190-191).

Federal involvement continued when, in 1946, the National Mental Health Act was passed, amending the Public Health Service Act of 1944. This act has become important, retrospectively, as the legislation that established training grants for institutions and fellowships to individuals to increase manpower in the mental health fields as well as being the legislation that established the National Institute of Mental Health; it is often forgotten, however, that one of the act's foremost purposes was the "prevention" of mental problems. In fact it was designed "... to develop, and assist States in the use of, the most effective methods of prevention, diagnosis, and treatment of psychiatric disorders" (Senate Report No. 1353, 79th Congress, 2nd session, p. 10).

The ideas involved in the legislation can be traced in part to Lawrence Kolb, who had become chief of the Division of Mental Hygiene in 1938. Kolb was particularly interested in the prevention of mental disorders and in research activities which would lead to that end. As a result of his interest, he advocated the creation of a national institute with its

own laboratories and research facilities (Rossi, 1962), which of course became manifest in the NIMH.

The Senate Report on this legislation made it clear that monies for prevention and research were to take priority over expenditures for routine treatment. A reading of the hearings on this legislation easily demonstrates that prevention was uppermost in the minds of many of its sponsors and supporters. Surgeon General Thomas Parran in his testimony strongly emphasized the need for prevention: "A sound program for public health action in the field of mental health should be built upon expanded research to learn causes, methods of prevention, and treatment of these disorders. . . . Research, on which depends our knowledge of the cause, prevention and cure of mental illness, has lagged far behind the investigations in other fields of medical science." (National Neuropsychiatric Institute Act, Hearings . . . on S. 1160, 1946, 79th Cong., 2nd Sess., p. 12).

In further testimony Dr. Martha Eliot of the Children's Bureau urged that preventive efforts be directed at children. The following sentences from her testimony demonstrate her interest in going beyond the child guidance clinics to prenatal counseling:

If we are to tackle this problem in a fundamental way, however, we cannot depend entirely on the clinic set-up to treat behavior problems after they start. The problem must be approached on the broad base of community health services for children. The service should start in the maternity clinic before the child is born, preferably through contact with the young parents who are about

to have their first child. Attitudes of parents are often set before the child is born and during the first days of the child's life (pp. 96-97).

Robert Felix, then of the Public Health Service, stressed the need for research in various areas, including nutrition, thus echoing the earlier concern of the Public Health Service:

Studies in the field of nutrition would help to evaluate the importance of various elements of our diet in the production of mental disease and the preservation of mental health

As in other public health problems, the epidemiology of mental disease must be thoroughly understood. We must know more of the influence of various ecological factors and which might be conducive to the development of abnormal conditions (p. 133).

Once the new institute was firmly established, the Division of Mental Hygiene was abolished in 1949 and NIMH became one of the National Institutes of Health.

Another major contribution of the 1940's was represented by Erich Lindemann's development of "crisis theory." As an outgrowth of his Coconut Grove fire studies he established the Wellesley Human Relations Service as a community mental health program to implement his prevention ideas (Caplan, 1964). The service eventually included a wide range of outreach and preventive programs primarily aimed at children, and which included discussions with parents of children entering kindergarten, workshops, and consultation with teachers, and identification of children with problems, in addition to short-term therapy (Klein, 1961).

The 1950's

Lindemann's crisis theory proved to be very popular and influential throughout the 1950's. Perhaps even more influential, however, were the number of studies published during that decade which explored the relationship of environmental factors to mental disorders, visibly demonstrating the shift made in the forties from eugenics to eugenics. That a relationship existed between environmental conditions and mental problems had been suggested and assumed throughout the century (e.g., White, 1917; Notes and Comments, 1918; Mental Hygiene, 1919; National Committee for Mental Hygiene, 1934; Treadway, 1936), but serious, broad-based studies had been lacking. However, in the fifties several studies explored this relationship: In 1959 Lieughton's study, attempting to link mental disorders and sociocultural forces appeared, and those of Ojemann and Prescott, who developed preventive programs among school children by modifying teaching methods and curricula, appeared in 1955 and 1957, respectively. Hollingshead and Redlich published their classic study of social class and mental illness in 1958. And Srole, Langer, Michael, Opler, and Rennie (1962) conducted in the early fifties what became known as the Midtown Manhattan Study, which identified stress factors as possible causal factors in three socioeconomic groups.

An interest in etiology and epidemiology seemed to spawn further interest in prevention. Or perhaps the right climate had finally developed. At any rate conferences and symposia were also devoted to the topic. In 1959 the International Association for Child Psychiatry and Allied Professions decided to focus the Congress of Child Psychiatry on primary prevention (Caplan, 1961). And in April 1957 two symposia addressed the

the issue of preventive psychiatry. One was sponsored by the Army Mental Hygiene Group, under the direction of Colonel Albert Glass, and held in Washington, D. C. (Walter Reed Army Institute of Research, 1958). The other was the First Institute on Preventive Psychiatry, sponsored by Ralph Ojemann and the State University of Iowa's Committee on Preventive Psychiatry, and held in Iowa City (Ojemann, 1957).

Concomitant with this interest, a heightened critical sense emerged, and standards in the area began to be questioned. At the Iowa institute, for example, Gottlieb and Howell criticized prevention programs for their lack of evaluation and argued for the greater need for research. They wondered whether psychiatry even knew how to train parents to raise their children. Rather than huge, all-inclusive programs, they argued for developing primary preventive programs around "specific factors in the genesis of illness." And, they maintained, even where some knowledge based on research existed, few efforts were made to see that it was applied (Gottlieb and Howell, 1957).

The Joint Commission on Mental Illness and Health

A similar critical point of view was emerging on the federal level. Under the Mental Health Study Act of 1955, Congress had authorized the study of the mental health field by the Joint Commission on Mental Illness and Health. The purpose of such a study was to provide for an "objective, thorough, and nationwide analysis" of mental illness and to develop recommendations regarding new developments or improvements which might result in reducing the "incidence of duration" of mental illness. The commission, made up of 45 individual members and supported by 36 national agencies,

reported its conclusions in 1961. In general the report's main thrust was not toward prevention, but when prevention was addressed it was in terms of basic research, and it strongly discouraged premature or unscientific findings from being disseminated.

The primary prevention of mental illness presents a twofold problem. First, no program of prevention through public education or other means should be undertaken without a thorough assessment of the available scientific knowledge and a grounding of the program in such knowledge. The importance of such a grounding has often been overlooked in the past. Second, advances in prevention of mental illness, as in its cure, depend on the development of the extensive research program proposed above (Joint Commission on Mental Illness and Health, 1961, p. 242).

The report did not attempt to disguise the fact that it was reacting to what it felt were the excesses and deficiencies of the mental hygiene movement in this regard. In fact, of major importance to the history of prevention was the report's strong indictment of the mental hygiene movement. (However, in order to protect the folk hero of mental health, it claimed that Clifford Beers had originally been more interested in the care of the mentally ill, rather than prevention, "but his doctor friends of those days were more interested in the possibilities of preventing mental illness" [p. 69]). It charged that the emphasis of the mental hygiene movement on prevention had been too global, broad, and optimistic, that it had viewed mental illness as though it were a disease like rickets and that in consequence the movement had viewed prevention as just a

matter of finding the equivalent of Vitamin D.

Our major criticism of the orientation of the mental hygiene movement toward prevention of mental illness is that, while its views . . . contain some broad biological truths, these truths are too diffuse for scientific application to human beings in a democracy. In 1960 we are not closer to predetermining reproduction of "good brains," or to identifying the "manifestly unfit" Thus, primary prevention of mental illness has remained largely an article of scientific faith rather than applicable scientific truth.

Nor have we as yet been able to control, or even agree on, a proper mental environment for our children (pp. 70-71).

Finally, the report quoted Robert Hunt (1958) that the traditional tools of the mental hygiene movement had prevented nothing: "Our hopes of preventing mental illness by mental health education and child guidance clinics have been disappointed and there is no convincing evidence that anyone has ever kept out of the state hospital by such measures . . ." (p. 9).

The report naturally became the source of heated controversy. Gerald Caplan, a leader in the emergent community mental health movement during these years, was clearly disappointed with the commission's report. He felt that it had violated the original mandate of the legislators which he saw as advocating a community and preventive effort. He also thought that the commission's recommendations clearly favored treatment over prevention and were largely restricted to the population of mentally ill adults. He believed, however, that President Kennedy in his message to

Congress following the report, had returned to the spirit of the legislators' intent and "made it clear that he was focusing on primary prevention" (Caplan, 1964a, p.7). Others echoed Caplan's concern about the report.⁶ In particular, Leon Eisenberg, in a speech delivered in 1962, felt that, although the commission may have been justified in some of its criticisms, it had gone too far (Eisenberg, 1966, p. 64).

It was perhaps fortunate that the National Committee for Mental Hygiene had changed its name to the National Association for Mental Health in the early fifties, for by the 1960's the mental hygiene movement, with its conceptualization of prevention, had clearly come under strong attack. While the idea of prevention had continued to attract adherents throughout the 1950's, the approach had significantly changed.

The 1960's

The interest in community mental health and the recommendations of the Joint Commission, together with President Kennedy's personal interest in mental disorders, culminated in the Community Mental Health Centers Act of 1963. Primary prevention per se was not listed as one of the five essential services (perhaps in partial response to the attitude of the Joint Commission), but preventive interests were served to some degree under the requirement to include consultation and education services and later under the added services of research and evaluation.

Continuing the trend and interest begun in the 1950's, the literature in the area of primary prevention expanded in the 1960's. For example, in 1964 Caplan's seminal work, Principles of Preventive Psychiatry, appeared and stimulated much interest. It provided a definition and model

of primary prevention and espoused crisis intervention (based on Lindemann) as a principal means of prevention. By 1962 the number of individual studies in the area was sufficient to warrant what seems to have been the first literature review of the area (see Eisenberg, 1962). A second review by Bolman and Westman (1967) divided the programs into three categories: child-centered prevention programs; family-centered programs; and and society-centered programs. And, taking stock of the situation in 1967, Bolman and Westman felt that one of the failures of the preventive effort was the inability of professionals to apply preventive knowledge:

There is not only a tendency to deal with parts rather the whole, but also a failure to use already accumulated knowledge. We agree with those who feel that, despite the real problems of vagueness of concepts, social resistances, and lack of research, there is a considerable amount of available knowledge and experience awaiting use (p. 1065).

Yet the voices of criticism continued to be heard in the sixties. One of the strongest of these was that of James Davis, who, under the aegis of Pennsylvania Mental Health, Inc., reviewed the published research literature on educational campaigns and "positive mental health" and in 1965 published his results and recommendations in Education for Positive Mental Health. He concluded that there were not studies bearing on "the relative contributions of past histories and contemporary environments to adult mental health." More significant to preventive campaigns, he claimed that the effect of media campaigns (such as the mental hygiene movement had used) had not been adequately studied to warrant any

any positive claims and furthermore that no-one had any real knowledge in the area to impart to the layman to begin with. In his words, ". . . mental health educators have nothing concrete and practical to tell the public" (Davis, 1965, p.131).

The 1970's

The literature of the 1970's reflected the increasing crescendo of interest in the topic that had begun in the decades before. This interest was perhaps best typified by the initiation in 1975 of the Vermont Conferences on the Primary Prevention of Psychopathology, and the publication each year of a volume devoted to primary prevention. But other examples are easy to find: In 1976 the Triparite Prevention Meeting was held in Maryland in 1976 and was hosted by the U.S., Canada, and United Kingdom. Its purpose was to clarify future directions in prevention policy in the areas of drug abuse, alcoholism, and mental health. In the same year the National Institute of Mental Health underwrote a Pilot Conference on Primary Prevention. The conference was held under the direction of the National Association for Mental Health in conjunction with the National Council of Community Health Centers and had come about partly because of the interest of community mental health centers in prevention (through their consultation and education services). That C and E functions were clearly not preventive at this time is made explicit several times in the published proceedings (Klein & Goldston, 1977). At one point the editors explain that "Consultation and education, although a required service, has become a term without precise meaning used to encompass and legitimize a variety of activities usually regarded to be of minor

significance among CMHC top leadership. The term 'prevention' is used frequently in the same vague way to gain acceptance for a range of popular activities having little or no demonstrably significant preventive impact" (pp. vi-vii).

By this point the criticism against earlier preventive efforts had become almost standardized, particularly the charge that claims had been made too early by reformers who were too enthusiastic. It is interesting to note that by 1976 even the National Association for Mental Health was making these charges--charges which allude to the earlier preventive direction of the National Committee for Mental Hygiene, the very precursor of the NAMH (Klein & Goldston, 1977).⁷

In 1977 Goldston, the director of primary prevention for NIMH, attempted to account for the "emergence" in the 1970's of primary prevention as a respectable area of interest among professionals. He speculated that the following four forces contributed: 1. the public consumer movement; 2. cost effectiveness considerations ("Growing awareness that primary preventive activities can be a major vehicle for eventual reduction of health care costs"); 3. a growing commitment to the notion that "community mental health practice implies responsibility for the mental health of an entire population and not merely for the casualties that appear at the doors of the mental health facility"; and 4. the inclusion of prevention as one of the five areas of emphasis in HEW's "Forward Plan for Health" in the 1970's, thus giving it official sanction and support (Goldston, 1971a, p. 22).

Whatever the contributing factors, the culmination of the seventies'

focus on prevention occurred in April 1978 when the Report to the President from the President's Commission on Mental Health was published. As is now common knowledge, it also emphasize the role of prevention. In preparing the report, the commission had assembled a Task Group on Prevention, which included such spokespersons for prevention as George Albee and Bernard Bloom. Albee maintains that, unlike other task group reports, the prevention report was "referred for special evaluation comment and criticism."

The report did not please one particular individual and he, in appropriate medical fashion, nudged the Commission into asking for another opinion from another psychiatrist. The second opinion came down heavily on the side of early treatment (secondary prevention) and suggested more research on high risk groups and on basic brain research to get at the 'causes of specific disorders' (Albee, 1979, p. 12).

The Task Group's report finally did get accepted, however, and the commission's recommendations included provisions for primary prevention and a national center for prevention. The commission's report stated that the major goals in prevention were: (1) preventing new cases of mental illness and severe emotional disturbances; (2) reducing the impact of dysfunctional stresses and life crises by developing coping skills; and (3) promoting 'the strengths, resources, and competencies of individuals, families, and communities.' The commission also concluded that help for children should become the first priority (HEW Task Force, 1978).

Following publication of the report, HEW formed a task force to analyze the implications and to propose legislation responsive to the

commission's recommendations. Although it was not the purpose or role of the HEW Task Force to be critical of the POMH's report, its report did include a section in its published analysis entitled "Challenges to a Mental Health Prevention Program." This analysis of prevention seemed to question the advisability of certain prevention efforts. If found, for example, that:

... in the area of functional mental disorders, data on the incidence of various mental disorders. . . are not yet available. . . causal agents of mental illness are far less specific (or have not been clearly identified), and the preventive agents are neither specific nor inexpensive to deliver. For example, while it is known that "good" parenting is essential for the healthy development of children, exactly what constitutes "good" parenting is less specific. Demonstration programs have shown that comprehensive efforts to develop the competence of parents and to provide health and social service programs can increase the competence of children. But often such programs increase the utilization of services, at least in the short run. The programs are neither specific nor inexpensive to deliver, nor do they "innoculate" children over a long period of time (pp. G-3--G-4).

However valid they may be, some of these points seem well worn by this date. Certainly the following statement has appeared in many guises over the decades: "Without a broad understanding of the etiology of psychopathology--plus a plan to identify specific antecedents and concomitants of mental and emotional problems--the expenditure of funds may not move

us much closer to preventing mental illness than we are now" (HEW Task Force, 1978, p. G-4).

In any event, the Task Force report resulted in the legislation now known as the Mental Health Systems Act, which became law in the fall of 1980. It was one of the purposes of the original bills, as introduced by Senator Kennedy and Representative Wasman, to encourage states to develop prevention programs and to that end authorized grants to any state agency for any of the following purposes:

1. providing assistance, through collection and dissemination of information, workshops, and other appropriate means, to mental health or other health personnel . . . ;
2. inservice training . . . in early identification of the potential causes of mental illness and early application of measures designed to prevent occurrence or aggravation of mental illness;
3. providing information to the general public on the importance of preventing mental illness and of the services available;
4. planning, and other activities at the State or interstate regional level to develop and coordinate, services to help prevent mental illness; or ---
5. demonstrating, in one or more mental health services areas of the State, the various means of preventing mental illness and otherwise promoting mental health (96th Cong., 1st session, S. 1117, pp. 13-14).

Although the year 1979 saw much discussion of prevention due to the proposed legislation among other factors it also became evident that divisions and factionalizations had occurred among prevention advocates.

Many of the divisive issues had a familiar ring: basic research vs. applied research, prevention of specific disorders vs. elevating the general quality of life, evaluating prevention efforts vs. assuming their workability, intervention vs. education, children vs. adults, etc.

On the one hand, NIMH seemed to take a stand against advocating global societal reforms in the name of prevention. Again cautioning against the overzealousness of the past, NIMH Director Herbert Pardes clearly preferred specific measures:

Mental health has been too ready to take on the world in past years, and I think we have to be a bit more humble. . . . The prevention program has to have relevance to mental health. There's a difference between broad societal issues and the purview of NIMH. . . and with broad issues of citizen organization and citizen empowerment, you've got to show me the very strict relationship to mental health (quoted by Herbert, 1979a, p. 9).

In fact, in 1978 and 1979 the NIMH priorities in prevention were narrowed to the following seven areas for the development of models of intervention: families undergoing marital disruption, children of severely disordered families, victims of natural disasters, children at risk following a death in the family, parental competency, children hospitalized for physical conditions, and anyone with high suicide risk (Herbert, 1979a).

Others, such as Albee, now argued for broader measures. The Fifth Vermont Conference was devoted to "prevention through political and social change," and that conference itself suggested, according to Albee, that "(1) we believe social forces cause psychopathology and (2) social change may well reduce or eliminate human distress," (Albee, 1979, p.13).

Wray Herbert, reviewing a prevention conference sponsored by The Alcohol, Drug Abuse and Mental Health Administration in 1979 found many hotly debated issues. Among them he discusses the priority of children, the issue of behavior change as the "key issue," and the question of when to apply prevention (Herbert, 1979b, p. 18). Thus the division in the field in the late 1970's seemed perhaps an almost inevitable consequence of the popularity and wide interest it enjoyed in the earlier part of the decade.

It remains to be seen whether or not the momentum gained in the 1960's and 1970's (particularly during the last five years of the seventies) will carry easily into the 1980's. In certain psychiatric circles, for example, prevention is in no danger of replacing treatment as a top priority item. In language which echoed that of the Joint Commissions's report in 1961, Lamb and Zusman in 1979 suggested that primary prevention was simply a fad, that its underpinnings were shaky, and that mental health monies were simply too precious to be diverted from treatment into prevention. In fact, they argued that prevention's appeal ". . . must be resisted by mental health professionals lest it become a glamorous rationalization for avoiding treatment of difficult, mentally ill persons, such as chronic psychotic, alcoholic, and addicted persons" (p. 16). And, in the closing months of the decade, the important position of prevention in the administration's mental health systems package had become somewhat diminished in its reworking by Senator Kennedy's Committee on Labor and Human Resources. In a time of governmental belt-tightening this was not surprising. Again, however, the situation was not novel--at a mental

hygiene conference held in 1912 one of the principal speeches had the following title: "Millions for Care and Cure, Nothing for Prevention" (Folks, 1912).

Conclusion

This brief overview documents that the primary prevention of psychopathology is not the brain-child of contemporary thought in psychology. Going back even a modest 80 years brings us into contact with both conceptual and action strategies to implement a preventive psychology.

We have seen that movements beginning at the turn of the century recognized the need to deinstitutionalize mental health by bringing services and interventions to the community, recognized the influence of environmental and societal forces on the establishment of mental illness, and focused on the young as likely targets for intervention. We also seem to have witnessed the repetitive diminution of interest and effect in these movements and a recurrent backlash of criticism and doubt.

While numerous factors have influenced this slackening of effort, several more universal trends appear to have established themselves throughout the eras. This review suggests that the field of primary prevention of psychopathology has failed to generate substantial empirical data-bases upon which coordinated theories or even consistent action strategies may be founded. It appears that in each era the failure to establish such a knowledge base has contributed to the loss of initiative and invited the criticism of detractors. This failure has also not allowed for the continuity of progress over time, as each new generation of preventionists has had to rely to a large extent on its own ingenuity,

energy, and resources in re-establishing credibility for its field of interest. This situation, happily, may be improving at the current time as various authors have suggested avenues which could be pursued and with new information becoming reliable. Cowen (1978), for instance, has suggested the analysis and modification of impactful social systems as well as competence training as two areas in which the knowledge base and technology are now sufficient for us to "be getting on with the show." Similarly the impact of disrupted social networks in marital separation has surfaced as a major stressor in current society (Crago, 1972).

Our reading of this literature suggests that two of the major preventive movements have been ill-fated as they have found themselves incorporated into the everyday reality and operations of service delivery settings. The evolution of the child guidance center movement as well as the CMHC movement thirty years later, as examples, appear to have squelched the very preventive idealism from which they emanated. Other authors e.g., Sarason (1977), not necessarily speaking from an historical perspective, have earlier alluded to the futility of trying to develop a psychology of prevention from a service delivery base. Perhaps as the focus of preventive efforts continues to shift from the prevention of "badness" to the fostering of positive growth and development, there will be less of a tendency for such efforts to become entrenched in service delivery settings and for the elimination of psychopathology to be the major criterion of success. This would not only free us from the burden of trying to reduce the incidence of our entity, which some people suggest does not even exist (e.g., Szasz, 1961), but at the same time defines many new criteria

by which the effectiveness of a psychology of prevention may be judged.

A third, seemingly universal, deterrent to any real progress in prevention as a movement, which this historical overview brings out, is the very real resistance from those not subscribing to such an ideology.

It is inevitable that a substantial group (likely a majority of mental health professionals) will at least passively, if not actively, resist embracing a preventive philosophy if this should imply an abandonment of the clinical enterprise or a substantial reallocation of resources away from direct service needs. Should prevention interventions prove to be effective in forestalling psychopathology (and possibly even capable of turning a financial profit) some converts might be made.

Fewer problems should be encountered in determining the wisdom of pursuing either the specific target or global approach in prevention. The field seems sufficiently devoid of both data and theory to encourage the pursuit of knowledge in each of those directions, and most interventionists seem currently to subscribe to a multi-dimensional approach. There does seem to be a consensus that we should stop overselling the possible truths of preventive efforts and establish and follow consistent evaluation strategies in our work.

Our intentions in this review were not to suggest what specific directions efforts in primary prevention may best take in the future. We realize that our work is limited both by its time perspective and scope and that it is based only on published materials. Rather, we hope this review serves to focus attention on the cyclical nature of interest in prevention, and we hope we have served to stimulate interest and thought

regarding what obstacles must yet be overcome in order for the seemingly erratic wellspring of interest in prevention in psychology to flow more smoothly.

Footnotes

¹Requests for reprints should be sent to Philip Balch, Department of Psychology, University of Arizona, Tucson, Arizona 85721.

²Dates appearing in parentheses following the name of a movement were selected by the authors for discussion purposes and are somewhat arbitrary in some instances.

³Although the term "mental hygiene" was proposed for Beers' new organization by Adolf Meyer, the prominent psychiatrist who worked closely with Beers, the term itself goes back to at least 1863 when it was used as the title of a book by Isaac Ray.

⁴In its language as well as its priorities this statement clearly foreshadows the community psychology movement in its initial stages in the 1960's.

⁵Citing Abraham Myerson's 1936 report that "a hundred per cent sterilization of mentally defective and hospitalized mentally ill persons would not radically modify the number of mentally ill or mentally defective individuals in the next generation," Greunberg quietly concludes that, given the use of sterilization by the Nazis, "this program does not recommend itself for mental disease prevention" (Gurenberg, 1953, p. 161). The issue was obviously not resolved with that statement, however.

⁶Caplan, himself, had faulted the child guidance clinics. But his criticism was directed at the clinics' gradual drift away from some of their original policies formulated in the 1920's, particularly those policies which dealt with primary prevention in the community. As alluded to earlier, because the community problems had seemed insurmountable, the clinics seemed to have taken the path of least resistance and

concentrated on direct clinical services (Caplan, 1961).

⁷For example, the following is an excerpt from the preface to the proceedings of the Pilot Conference sponsored by NIMH:

. . .the mental health field was notably inhibited in the development of an effective preventive component. This situation is in part a reaction to unsupported claims made by enthusiastic advocates of well-intended preventive efforts. Considerable skepticism has been evoked in response to programs described as being preventive because such efforts lacked reliable evaluation and were applied unsystematically to small random populations (Klein & Goldstor, 1977, p. v.).

⁸Although the National Committee for Mental Hygiene has frequently been faulted, either directly or through implication, for its overzealousness and its extravagant claims, the president of the National Committee for Mental Hygiene was cautioning against the same dangers in 1912: "We must take care that the cause of mental hygiene is not injured by rash enthusiasts who propose the unattainable, or who fanatically urge the immediate adoption of ill considered plans of reform (Baker, 1912, p. 10).

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